

# LICHEN SCLEROSUS

## Information for Referring Doctors

One of our aims at the Dermatology/Vulval conditions clinic is to share the care of chronic patients as much as possible with the referring doctor. Improving the knowledge and understanding of these conditions is also an important goal. As such we have provided this information sheet to try to assist doctors caring for these women.

## What is Lichen Sclerosus? (LS)

Lichen sclerosus is an uncommon condition in which a characteristic type of inflammation of the dermis causes a distinctive skin appearance. The cause is not known, but is likely to be autoimmune.

LS can occur anywhere on the body but most commonly affects anogenital skin, especially in females.

In men and boys the penis (particularly if uncircumcised) and perianal area may be affected, and phimosis and urethral stenosis may develop.

**In women and girls the vulva and perianal area is involved but the vagina is spared.** Vulval lichen sclerosus has previously been known by a number of names, including leukoplakia and vulval dystrophy. It can occur at any age but is most commonly seen around the time of menopause or before puberty.

## Symptoms and Signs, Risks and Associations of Vulval Lichen Sclerosus

General health remains normal. **Itch and soreness** are the main symptoms but sometimes the patient is **asymptomatic**. Initially the skin is red and inflamed but later becomes white, shiny, crinkly and atrophic. Sometimes patches of affected skin can be quite lichenified. Erosions, bullae or purpura may occur.

In longstanding disease there is usually an **alteration of the normal anatomy** of the vulva. The labia minora may shrink or be completely resorbed onto the labia majora, and the opening to the vagina may become

narrowed, resulting in difficult and painful intercourse. The clitoris can become buried due to scarring of the clitoral hood. The vagina is unaffected.

Longitudinal studies suggest a roughly 4% (reports range from 1-11%) risk of development of squamous cell carcinoma within areas affected by LS. It is likely the risk is highest in those with a hyperkeratotic tendency, and review more frequently is suggested for these patients.

There may be a family history of this skin disease, or of autoimmune diseases such as vitiligo, alopecia areata, diabetes mellitus or pernicious anaemia. In adult women it can sometimes be associated with autoimmune thyroid dysfunction. **Our recommendation is to screen new patients with LS by performing fasting BSL, FBE, TFTs, thyrogastic antibodies and antinuclear antibodies.** Would you kindly manage future testing.

## Aims of Treatment for Vulval Lichen Sclerosus

- Control of symptoms such as itch, soreness, dyspareunia
- Minimization of scarring and alteration of normal vulval architecture
- Surveillance for squamous cell carcinoma
- Reduction in risk for SCC (data is uncertain regarding the effect of corticosteroid and reduction in cancer risk, but the reduction in chronic trauma through scratching is likely in itself to reduce cancer risk).

## Management

- Genital hygiene

Avoidance of irritants and soaps is most important. Daily pads are discouraged. Sexual lubricants are often necessary. Moisturizers and/or barrier ointments (such as **sorbolene** and **dermeze**) are encouraged on a daily basis if the skin is particularly dry. A detailed information sheet is supplied to patients.

Acknowledgement: **Dr. Belinda Welsh (Dermatologist), Dr Karen Berzins (Sexual Health Physician)**

This fact sheet is designed to provide you with information on Lichen Sclerosus. It is not intended to replace the need for a consultation with your doctor. All clients are strongly advised to check with their doctor about any specific questions or concerns they may have. Every effort has been taken to ensure that the information in this pamphlet is correct at the time of printing.

# LICHEN SCLEROSUS

- **Topical steroids**

The most successful treatment is steroid ointment (typically **Diprosone OV** or **advantan ointments**). These are used once or twice daily for the first month, usually daily in the 2nd month, then at reducing levels depending on symptoms and the appearance of the skin. A 30g tube should last at least 3 months and is quite safe at this level of usage. Maintenance treatment is often only x1-2 applications per week. There may be a burning sensation when steroid ointment is first applied, but this usually disappears within 10 minutes. If it persists, the steroid should be stopped, as an irritant or allergic contact dermatitis may be the cause. Review at the vulval clinic is recommended.

In general, it is preferable to use medication often enough to avoid all symptoms. Treatment based on the presence of symptoms can risk ongoing scarring. For some women, progressive LS can occur without symptoms. Also, despite resolution of itch during treatment, there can sometimes still be mild active disease. Pulsed treatment, such as weekly, has very little risk of steroid induced skin atrophy and is often recommended as the maintenance dose.

Topical androgens have previously been used for LS, but studies have shown that their benefits are not better than placebo.

- **Symptom flares**

When symptoms have been controlled and a maintenance level of medication has been successful for some time, acute symptoms of LS may occasionally occur. Treatment frequency will need to be increased (usually daily) for a week or more. It is advisable to exclude candidal, bacterial and, if the skin is split, herpes infections.

- **Followup**

Once the condition is controlled, we recommend 3-6 monthly review in the initial 1 to 2 years, to observe the clinical pattern of LS. Well controlled LS shows persistence of the anatomical changes to the labia and clitoral areas and pale skin areas (sometimes reddened smooth areas also), but the skin will be smooth. At this stage review can be reduced to x1-2

Acknowledgement: **Dr. Belinda Welsh (Dermatologist), Dr Karen Berzins (Sexual Health Physician)**

annually lifelong, and women will be encouraged to self monitor using a mirror more frequently.

Where LS has a tendency to be lichenified, followup will need to remain at **3-6 monthly**. At review, visual or palpable changes should be specifically sought. These include thickening, white roughened patches, induration, lumps or non-healing ulcers or fissures. **Any suspicious areas require biopsy to exclude SCC.**

Occasionally architectural changes such as introital narrowing require surgical treatment, but ongoing topical treatment will continue.

## **The Role of the Vulval/Dermatology Clinic.**

The aim of the clinic is to make or confirm the initial diagnosis of LS, and then to gain symptomatic control of the disease. Once this is achieved we hope it will be possible for the referring doctor to perform ongoing surveillance through vulval examination at least 6 monthly. If there are any problems with this, or if there are suspicious areas, please be in touch. Urgent review or advice can be arranged with the clinic. MSHC operates also on a walk in basis for acute symptoms.

This fact sheet is designed to provide you with information on Lichen Sclerosus. It is not intended to replace the need for a consultation with your doctor. All clients are strongly advised to check with their doctor about any specific questions or concerns they may have. Every effort has been taken to ensure that the information in this pamphlet is correct at the time of printing.